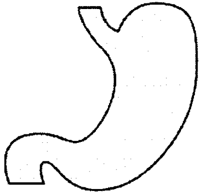


GASTROENTEROLOGY CONSULTANTS OF NORTHERN VIRGINIA
CHARLES J. HUH, M.D.
3650 Joseph Siewick Drive, Suite 107
Fairfax, VA 22033
703-262-0200 Fax: 703-262-0211

PATIENT REGISTRATION (please print)

First Name____________________________ Last Name ________________________Middle_______________

Date of Birth: ______/______/_____ Social Security #_____________________ Sex: Male / Female (circle one)

Home Address____

____

Home Phone_______________________ Cell Phone ___________________Work Phone ___________________

Email Address____

Marital Status______________ Occupation____________________ Employer________________________

Employer Address ____

Spouse Name or Parent Name ______________________________ Phone: ______________________________

Emergency Contact: Name _______________________________ Phone: _______________________________

Pharmacy (Full Address and Phone #) ____

____

Referring Physician or Primary Care Practitioner ____

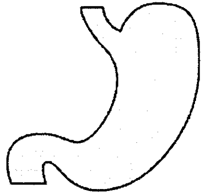
Address/Phone Number ____

I______________________, here by authorize Charles J. Huh, M.D. to apply benefits on my behalf for covered services needed. I request payment from my insurance company, be made directly to Charles J. Huh, M.D.

I certify that the information I have reported with regard to my insurance coverage is correct. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

_____________ ____

Date Signature of Subscriber or Beneficiary:



GASTROENTEROLOGY CONSULTANTS OF NORTHERN VIRGINIA
CHARLES J. HUH, M.D.
3650 Joseph Siewick Drive, Suite 107
Fairfax, VA 22033
703-262-0200 Fax: 703-262-0211

PATIENT QUESTIONNAIRE **Date:** ______________

First Name ________________________________ **Last Name** ______________________________ **Middle** (initial) ______

DOB:______________

1. Height. ________ Weight ______ lbs.

2. What is the reason for this doctor's visit? ____

3. What other medical conditions do you have? ____

4. Specifically, do you have any of the following (please circle all that applies): Rheumatic heart disease, Heart valve replacement, vascular surgery with graft replacement, History of heart valve infection? ________________________

5. What medications do you take on a regular basis? ____

6. Please list any allergies to any medications ____

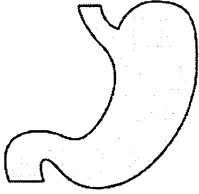
7. What surgeries have you had in the past? ____

8. Do you smoke or chew tobacco? (Yes/No) If so, how often? ____________________________________

9. Do you drink alcohol? (Yes/No) If so, how often? ____

10. Does any Illness or condition seem to run in your family? If so, please list: ______________________________

Office Use Only:
Charles J. Huh, M.D. Notes:



GASTROENTEROLOGY CONSULTANTS OF NORTHERN VIRGINIA
CHARLES J. HUH, M.D.
3650 Joseph Siewick Drive, Suite 107
Fairfax, VA 22033
Fax: 703-262-0211 Phone: 703-262-0200

Colonoscopy Consent Form

What is a colonoscopy? Colonoscopy enables your doctor to examine the lining of your colon (large intestine) for abnormalities by inserting a flexible tube into your anus and slowly advancing it into the rectum and colon. Please ask your doctor about anything you do not understand.

Can I take my current medication? Most medications can be continued as usual, but some medications can interfere with the preparation of the examination. Inform your doctor about medications you are taking, particularly aspirin products, arthritis medications, anticoagulants (blood thinner), insulin or iron products. Also, be sure to mention allergies you have to medications.

Alert your doctor if you require antibiotics prior to dental procedures, because you might need antibiotics before a colonoscopy as well.

What happens during a colonoscopy? Colonoscopy if well-tolerated and rarely causes much pain. You might feel pressure, bloating or cramping during the procedure. You will lie on your side or back while your doctor slowly advances a colonoscopy through your large intestine to examine the lining. Your doctor will examine the lining again as he or she slowly withdraws the colonoscopy. The procedure itself usually takes less than 60 minutes, although you should plan on two to three hours for waiting, preparation and recovery.

In some cases, the doctor can't pass the colonoscopy through the entire colon to where it meets the small intestine. If this should occur, your doctor may then recommend an additional x-ray test.

What if the colonoscopy shows something abnormal? If your doctor thinks an area needs further evaluation, he or she might pass an instrument through the colonoscopy to obtain a biopsy (a sample of the colon lining) to be analyzed. Biopsies are used to identify many conditions, and your doctor might order one even if he or she doesn't suspect cancer. If a colonoscopy is being performed to identify sites of bleeding, your doctor might control the bleeding through the colonoscopy by injecting medications or by coagulation (sealing off bleeding vessels with heat treatment). Your doctor might also find polyps during colonoscopy; he or she will most likely remove them during the examination. These procedures don't usually cause any pain.

Preparation: You will be given a separate instruction sheet detailing the preparation.

Risks: The risks are minimal and include pain, bleeding, and perforation, which is a tear in the lining of your gastrointestinal tract. These risks occur less than 1% of the time. Other risks include reaction from the medication used for sedation.

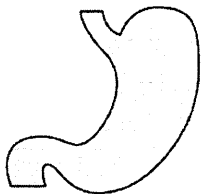
Alternatives: There are alternative diagnostic and/or therapeutic approaches including x-ray, which are usually a less accurate means of testing; and surgery, which is more invasive.

Note: If for any reason you need to re-schedule your procedure, you must give ten (10) business days notices. Otherwise, there will be a $150.00 charge.

I have read the above information and understand the indications and risks of this examination. I consent to the taking and reproduction of any photographs of the procedure for medical purposes. I hereby authorize and permit Charles J. Huh, M.D. to perform this procedure.

Print Name________________________________ **Sign** __________________________

Date ____________________________ **Witness** ____________________________



GASTROENTEROLOGY CONSULTANTS OF NORTHERN VIRGINIA
CHARLES J. HUH, M. D
3650 Joseph Siewick Drive, Suite 107
Fairfax, VA 22033
Fax: 703-262-0211 703-262-0200

Upper Endoscopy (EGD) Consent Form

What is an upper endoscopy? Upper endoscopy lets your doctor examine the lining of the upper part of your gastrointestinal tract, which includes the esophagus, stomach and duodenum (first portion of the small intestine). Your doctor will use a think flexible tube called an endoscope, which has its own lens and light source, and will view the images on a video monitor. You might hear your doctor or other medical staff refer to upper endoscopy as upper GI endoscopy, esophagogastroduodenoscopy (EGD) or pan endoscopy. Please ask your doctor about anything you do not understand.

Why is upper endoscopy done? Upper endoscopy helps your doctor evaluate symptoms of persistent upper abdominal pain, nausea, vomiting, or difficulty swallowing. It is an excellent test for finding the cause of bleeding from the upper gastrointestinal tract. It is also more accurate than X-ray films for detecting inflammation, ulcers and tumors of the esophagus, stomach, and duodenum.

Your doctor might use upper endoscopy to obtain a biopsy (small tissue samples). A biopsy helps your doctor distinguish between benign and malignant (cancerous) tissues. Your doctor might use a biopsy to test for Helicobacter pylori, bacterium that causes ulcers. Your doctor might also use upper endoscopy to perform a cytology test, where he or she will introduce a small brush to collect cells for analysis.

Upper endoscopy is also used to treat conditions of the upper gastrointestinal tract. Your doctor can pass instruments through the endoscope to directly treat many abnormalities with little or no discomfort. For example, our doctor might stretch a narrowed area (dilation); remove polyps (usually benign growths) or treat bleeding.

Preparation: You will be given a separate instruction sheet detailing the preparation.

Risks? The risks are minimal and include pain, bleeding, and perforation, which is a tear in the lining of your gastrointestinal tract. These risks occur less than 1 % of the time. If stretching or dilation of the esophagus is performed, the risk of perforation is slightly greater. Other risks include reaction from the medication used for sedation.

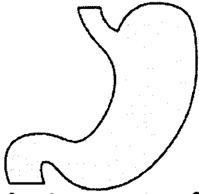
Alternatives: There are alternative diagnostic and/or therapeutic approaches including X-ray, which are usually a less accurate means of testing; and surgery, which is more invasive.

Note: If for any reason you need to re-schedule your procedure, you must give ten (10) business days notices. Otherwise, there will be a $150.00 charge.

I have read the above information and understand the indications and risks of this examination. I consent to the taking and reproduction of any photographs of the procedure for medical purposes. I hereby authorize and permit Charles J. Huh, M.D. to perform this procedure.

Print Name ______________________________ Sign ______________________________

Date ______________________________ Witness ______________________________



PRIVIA
MEDICAL GROUP

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Privia, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in the Privia network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of services provided to me by Privia and its care centers, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent to Treatment

As a Privia patient, I voluntarily consent to the rendering of such care and treatment as the Privia providers and personnel, in their professional judgment, deem necessary for my health and well-being.

My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Privia provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that Privia may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Privia.

I understand that I may voluntarily "opt-in" to receive automated text message communications from Privia and its partners by informing my provider's staff or visiting "My Profile" on my Privia Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received Privia's *Financial Policy* and *Notice of Privacy Practices*. I agree to the terms of Privia's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by Privia providers.

Printed Name of Patient: ______________________________ **Date:** ______________

➔ **Signature:** ____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

Note: If patient declines to participate in HIE, patient must follow the appropriate procedure outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly.